Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The purpose of a Psychiatric Residential Treatment Facility (PRTF) is to provide full-time psychiatric treatment for children under age twenty-one (21) with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but whose symptoms are severe enough to require supervision/intervention on a twenty-four (24) hour basis. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22). (42 CFR 441.151 (c)(1)(2)). The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR 441.152 (a)(3))

The Division of Medicaid (DOM) is responsible for determining whether a Psychiatric Residential Treatment Facility (PRTF) meets the Medicaid requirements for authorized reimbursement.

A facility requesting certification as a Medicaid-authorized PRTF must submit a completed provider enrollment packet. All enrollment forms must be signed and returned to the fiscal agent along with all requested documentation. When all information is received it will be reviewed and, if complete, submitted to the Executive Director of DOM for approval or disapproval. If approved, the enrollment forms will be returned to the fiscal agent and a provider number will be assigned. If the Executive Director disapproves, the facility will be notified in writing and the reasons for the disapproval will be clearly stated.

Out-of-state facility applications will be considered ONLY IF they can justify to DOM that a need exists for their services which cannot be met by the same or similar services within the state of Mississippi.

A PRTF provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

PRTF's participating in the Medicaid program are required to have the following staff:

1. **Administrator:** The governing body of the Psychiatric Residential Treatment Facility (PRTF) must appoint an administrator to be responsible for the overall management of the facility. The administrator must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The administrator must be responsible for the fiscal and administrative support of the facility's clinical program.

2. **Medical Director:** The facility must appoint a medical director to be responsible for coordinating medical services and directing resident treatment. The medical director must be a board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.

3. **Clinical Director:** The facility must appoint a full-time director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be a board-certified child/adolescent psychiatrist, a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, a licensed psychologist who is experienced in child/adolescent mental health treatment, a psychiatric mental health nurse practitioner (PMHNP) who is experienced in child/adolescent mental health treatment, or a licensed certified social worker who is experienced in child/adolescent mental health treatment.

   A board-certified child/adolescent psychiatrist (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) may serve as both medical director and clinical director provided that he/she is a full-time employee.

3. **Professional staff:** The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate resident supervision twenty-four (24) hours a day. At least fifty percent (50%) of the professional staff hours must be provided by full-time employees. Professional staff must be appropriately licensed and trained/experienced in providing mental health treatment. These staff members will include, but not be limited to, the following:

   - A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry
   - A licensed psychologist
   - A registered nurse
   - A licensed certified social worker
   - A certified teacher
   - A recreation specialist

   The PRTF must also have access, through full/part-time or contract employment, the services of:

   - A licensed occupational therapist OR credentialed creative arts (art, movement/dance,

music, etc.) therapist,

- A rehabilitation counselor, **AND**
- A licensed speech-language pathologist

The PRTF must notify the Division of Medicaid (DOM) of changes in the Administrator, Medical Director or Clinical Director. DOM must receive the notification in writing within seventy-two (72) hours of the effective change.

PRTF services are appropriate when a child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis. A board-certified child/adolescent psychiatrist (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) with admitting privileges must approve each admission.

When applicants are approved for PRTF admission by the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid, they are authorized a limited number of hospital days for that admission. It is the PRTF's job to help the child accomplish his/her treatment goals within that time frame. If treatment goals cannot be reached within the time allotted, the PRTF must justify to the UM/QIO why additional treatment time is needed. Refer to Provider Policy Manual Section 18.11 for Continued Stay policy.

The role of the peer review organization UM/QIO is to determine the medical necessity of PRTF services for child/adolescent Medicaid beneficiaries with psychiatric diagnoses, the appropriateness of a particular PRTF setting for each child, and the number of days reasonably required to treat each child's condition.

The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR 441.152 (a)(3)) The general expectation is that this level of symptom reduction/resolution can be reached within one hundred eighty (180) days of admission.

The need for PRTF admission must be supported by documentation that:

- The child has a diagnosable psychiatric disorder. (42 CFR 456.180(b)(1)) Admission for a primary diagnosis of substance abuse is not authorized.
- The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
- The child's psychiatric symptoms (disturbance of thought and/or mood, disruptive behavior, disturbances in social/family relationships) are severe enough to warrant residential treatment under the direction of a psychiatrist (42 CFR 441.152 (a)(2)).
- The referring psychiatrist or psychologist advises that residential treatment is needed (42 CFR 441.152 (a)(2)).
- At least one of the following:
    - The child has failed to respond to less restrictive treatment in the last three (3) months, **OR**
    - Adequate less restrictive options are not available in the child's community (42 CFR 441.152 (a)(1)), **OR**
    - The child is currently in an acute care facility whose professional staff advise that residential treatment is needed

- The admission has been certified by the UM/QIO as medically and psychologically necessary. (42 CFR 441.152)

If a facility provides for the use of seclusion/restraint, it must inform the incoming resident and his/her parent/guardian at the time of admission of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program The facility must provide the parent/guardian with a copy of its policy regarding seclusion/restraint and obtain a signed acknowledgment from the parent/guardian documenting that the policy was explained and a copy given to them. This acknowledgment must be filed in the resident's record. (42 CFR 483.356(c)) The facility must inform the parent/guardian of his/her right to be notified within 24 hours after any special procedure is applied with his/her child. (42 CFR 483.366(a)) The PRTF must also provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization and document in the record that this was done. (42 CFR 483.356(d))

When a child is denied admission, the PRTF must notify the referral source of the reason(s) for the denial within seventy-two (72) hours. The PRTF must keep a log of denial notifications for review by DOM.

Weekend admissions are not allowed since all PRTF admissions are required to be of a non-emergency nature. If a resident is admitted after 5:00 p.m. on a Friday, covered days will not begin until the following Monday. DOM will not reimburse for non-covered days of stay.

DOM will not reimburse for any days of stay not certified by the UM/QIO.

The fourteen (14) days following admission are considered to be a time of diagnostic evaluation, when the information needed for effective treatment planning is gathered and assessed. The diagnostic evaluation must document the need for the PRTF level of care (42 CFR 441.155(b)(1)). The assessment process must include, but is not limited to, the following:

- A psychiatric evaluation
- A medical history and examination (42 CFR 441.155(b)(1))
- A psychosocial assessment which includes a psychological profile, a developmental profile, a behavioral assessment (42 CFR 441.155(b)(1)), and an assessment of the potential resources of the resident's family (42 CFR 441.156(b)(2))
- A Child and Adolescent Needs and Strengths (CANS-MH) assessment
- An educational evaluation
- A nursing assessment
- A nutritional assessment, if indicated

Therapeutic leave is not allowed during the fourteen (14) day assessment period.

The treatment planning process is a collaborative venture through which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each resident. The treatment plan charts a course designed to help the resident move to a less restrictive level of care as quickly as possible. (42 CFR 441.154(b)) An initial treatment plan must be in effect within seventy-two (72) hours after the resident's admission to the facility. The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the resident's admission. (42 CFR 441.154(a)) The treatment plan document must contain evidence of the resident's and his/her parent/guardian's active participation in the treatment planning/review/revision process (42 CFR 441.155(b)(2)).

Composition of Treatment Team:

The treatment team should include as many staff as possible who are involved in the treatment of the resident. At a minimum, the team must consist of the following:

1. EITHER a board-certified child/adolescent psychiatrist (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) (42 CFR 441.156(c)(1))

   OR

   A Psychiatric Mental Health Nurse Practitioner (PMHNP) AND a physician licensed to practice medicine or osteopathy

   OR

   A licensed psychologist AND a physician licensed to practice medicine or osteopathy (42 CFR 441.156(c)(2)

   AND

2. EITHER a licensed certified social worker who has a minimum of one year's experience in treating children with serious emotional disturbances (SED) (42 CFR 441.156(d)(1));

   OR

   A registered nurse who has a minimum of one year's experience in treating individuals with SED (42 CFR 441.156(d)(2)).

Elements of Treatment Plan

The treatment plan delineates all aspects of the resident's treatment and includes, at a minimum:

- A multi-axial diagnosis
- An assessment of the resident's immediate therapeutic needs (42 CFR 441.156(b)(1))

- An assessment of the resident's long-range therapeutic needs (42 CFR 441.156(b)(1))
- An assessment of the resident's personal strengths and liabilities (42 CFR 441.156 (b)(1))
- Identification of the clinical problems that are to be the focus of treatment
- Measurable and realistic treatment goals for each identified problem
- Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement (42 CFR 441.156(b)(3))
- Specific treatment modalities and/or strategies that will be employed to reach each objective (42 CFR 441.156(b)(4)), e.g. psychotherapy (individual, family, group), medication, behavior modification programs, etc. Special procedures (i.e. those providing for the seclusion or restraint of a resident) must not be included in the treatment plan unless justified by evidence (current or historical) of aggressive behavior which cannot be controlled by less restrictive interventions. If special procedures become necessary, the treatment plan must be amended or modified within one (1) working day of the first incident to reflect the use of the least restrictive necessary measures.
- The clinician identified as responsible for each aspect of treatment
- Identification of goals, objectives and treatment strategies for the family as well as the resident, and identification of the clinician responsible for family treatment. If a geographically distant therapist will be utilized, this must be specified in the treatment plan.
- An individualized discharge plan that includes:
    - Discharge criteria, indicating specific goals to be met, and
    - An estimated discharge target date
    - No later than seven (7) days prior to discharge the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the resident. ("at an appropriate time" 42 CFR section 441.155(b)(5)) Refer to Provider Policy Manual Section 18.12 for Discharge/Aftercare policy.

Treatment Plan Review and Revision

The treatment team will meet to staff each resident and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first fourteen (14) days following admission, once at the conclusion of the first month of stay, and once a month thereafter.

The treatment review team will assess the resident's progress in treatment by:

- Noting treatment successes (which objectives and/or goals have been achieved and when) and explaining treatment failures
- Making changes in the treatment plan as needed (42 CFR section 441.155(c)(2))
- Re-assessing the child's need for continued residential care, as opposed to less restrictive

treatment (42 CFR section 441.155(c)(1))

- Noting the child's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed

Active treatment (42 CFR section 441.154): The use of the term "treatment" in this manual refers to the active treatment of the resident. Active treatment is a process comprising:

- Multi disciplinary diagnostic assessment (42 CFR section 441.155(b)(1))
- Interdisciplinary treatment planning (42 CFR section 441.154)
- Therapeutic intervention (42 CFR section 441.155(b)(4))
- Treatment evaluation/revision (42 CFR section 441.155(c))
- Discharge/aftercare planning (42 CFR section 441.155(b)(5))

Psychotherapy is defined as the intentional, face to face interaction (conversations or non-verbal encounters, such as play therapy) between a mental health professional and a client (an individual, family, or group) in which a therapeutic relationship is established to help resolve symptoms of the resident's mental and/or emotional disturbance. It is required that all individual therapy, family therapy and group therapy will be provided by master's level mental health therapists.

Individual therapy is defined as psychotherapy that takes place between a mental health therapist and a resident.

Family therapy is defined as psychotherapy that takes place between a mental health therapist and a resident's family members or guardians, with or without the presence of the resident. If a resident is in the custody of the Department of Human Services (DHS), family therapy may also include others (DHS representatives, foster family members) acting *in loco parentis*.

Group therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2), but not more than eight (8) residents at the same time. Groups of up to twelve (12) participants are allowed if the primary therapist for the group is assisted by a co-leader. Group co-leaders are not required to be master's level therapists. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, self-esteem enhancement, etc.

Milieu therapy is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Emphasis is placed on clear, healthy, respectful communication between resident/resident, staff/staff, and staff/resident, and on shared problem-solving and decision-making. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process.

One essential component of milieu therapy is the community meeting. This is a time when all residents and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions, set goals, resolve conflicts and discuss ideas that may enhance treatment.

Therapeutic Pass/Therapeutic Leave are defined as those times when a resident is permitted time away from the PRTF to practice skills learned in treatment or to work on significant relationships in a setting that is less structured and controlled. **Therapeutic Pass** refers to "away" time of less than eight

(8) hours. **Therapeutic Leave** refers to "away" time of eight (8) hours or more in the same calendar day. A single day of therapeutic leave is determined by the resident's absence from the facility for eight (8) hours or more between the hours of 12:01 a.m. and 11:59 p.m. on any given day. In either case, goals for the period of absence should be identified and documented. Therapeutic Leave is not allowed during the fourteen (14) day assessment period following admission.

Creative arts therapies are defined as those therapies (art, movement/dance, music, poetry, etc.) in which a qualified professional uses the creative process and the resident's response to the created product to help the resident resolve emotional conflicts, increase self-awareness, develop social skills, manage behavior, solve problems, reduce anxiety, improve reality orientation, and/or increase self esteem.

Occupational therapy is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the resident achieve functional outcomes that promote the highest possible level of independence.

Recreation therapy is defined as a process that utilizes recreation services for purposive intervention in physical, emotional and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the resident.

Speech-Language Pathology is defined as remedial assistance with speech and/or language problems provided by a licensed speech-language pathologist.

Individual Therapy

A minimum of one (1) hour of individual therapy must be provided each week unless its contraindication is documented in the treatment plan. It is required that providers of individual therapy will be master's level mental health therapists.

Family Therapy

Each resident's family, guardian, or person acting *in loco parentis* must participate in family therapy at least twice a month unless its contraindication is documented in the treatment plan. If the resident's family is more than a two (2) hour drive from the PRTF, one (1) face-to-face family therapy session and one (1) therapeutic conference call will be acceptable. Both of these contacts must be therapeutic in nature, i.e. to discuss the resident's functioning, treatment progress, goals and objectives. Social visits or phone calls are not considered family therapy.

Residents who are in the custody of the Department of Human Services (DHS) should complete one (1) face-to-face family therapy session with the social worker in the county of the PRTF and complete the second family therapy session via telephone with the social worker in the home county.

A geographically distant therapist may provide family therapy when there are family issues that must be resolved or ameliorated before face-to-face sessions that include the resident can be productive and therapeutic. Distance alone is not justification for prescribing off-site therapy. When off-site therapy is appropriate, the treatment plan must identify the off-site therapist, indicate the goals for such therapy, and specify how information will be exchanged between the PRTF and the off-site therapist. Collaboration between therapists is the responsibility of the PRTF and must be documented in the clinical record.

It is required that providers of family therapy will be master's level mental health therapists.

Group Therapy

Each resident must participate in a minimum of three (3) hours of group therapy, provided in at least three (3) sessions, each week unless contraindication is documented in the treatment plan. The manner in which services are delivered (length, frequency, and timing of sessions) should be determined by what is developmentally appropriate for each resident. It is required that providers of group therapy will be master's level mental health therapists although larger groups (up to twelve (12) participants) may be co-led by a person with a lesser level of training.

Milieu Therapy

Milieu therapy must be provided twenty four (24) hours a day by all PRTF staff. Some of the indicators that a therapeutic milieu exists are:

- Community meetings are held at least daily and are attended by all residents and most, if not all, professional and direct care staff.

- The focus of community meetings is good communication and collaboration among residents and staff to solve problems, make community decisions, and introduce/discuss ideas/suggestions that will enhance treatment.

- Resident's are knowledgeable about their treatment and actively participate in goal-setting and treatment evaluation.

- The physical environment of the facility reflects a warm, child-friendly atmosphere with treatment-oriented information (ex: motivational/educational posters, schedules of activities, requirements for level systems, rules for unit, etc.) written in positive terms and age appropriate language. Materials are posted in a manner that is highly visible and easily accessible to residents.

Special procedures, **seclusion and restraint**, should be used as an immediate response only in emergency safety situations (42 CFR 483.356(a)(1)) when needed to help a resident regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. It should be noted that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for residents in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

Staff Training

If a facility provides for the use of seclusion/restraint, all staff who have direct resident contact must have ongoing education, training, and demonstration of knowledge of the proper and safe use of restraint **and** alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method which does not involve restraining a resident in a face-down or spread-eagle (legs apart) position.

Resident/Parent Notification

If a facility provides for the use of seclusion/restraint, it must inform the prospective resident and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. In the event that a resident requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than twenty four (24) hours after the initiation of the procedure. (42 CFR 483.366(a))

Definitions

Seclusion is the involuntary confinement of a resident in an area from which s/he is physically prevented from leaving. It is used to insure the physical safety of the resident or others and to prevent the destruction of property or serious disruption of the milieu.

Restraint is the restriction of a resident's freedom of movement or normal access to his/her body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the resident's physical safety.

- **Personal Restraint** is the restraint of a resident through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a resident from causing harm to self or others or to prevent destruction of property.

- **Mechanical Restraint** is the restraint of a resident through the use of any physical or mechanical device, material or equipment attached or adjacent to the resident's body that s/he cannot easily remove.

- **Pharmacological Restraint** is the use of a medication, which is not a standard part of the resident's treatment regimen, to control or alter the resident's mood or behavior or to restrict freedom of movement. Pharmacological restraint is used to insure the safety of the resident or others through a period of extreme agitation when less restrictive measures have not been effective.

- **Medication Adjustment** refers to the use of a resident's routine medication in a *non-routine way* to help the resident through a period of heightened stress or agitation, e.g. ordering the administration of an extra dose (usually in a lower amount) of the same (or similar, from the same class) medication that is already part of the resident's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the resident's treatment plan. Medication adjustment is not considered to be a special procedure. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the resident (and in some cases may be requested by the resident). Standing PRN (as needed) orders for medication adjustments are acceptable, while standing PRN orders for pharmacological restraint are prohibited.

Appropriate Use

Seclusion or restraint may be used only in situations where less restrictive interventions have been determined to be ineffective. Neither procedure may be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a resident's behavior, or as a substitute for individualized treatment. (42 CFR 482.356(a)(1)) Any use of seclusion or restraint must be:

- In accordance with the resident's treatment plan (if the treatment plan does not provide for the use of seclusion/restraint prior to its use, the plan must be modified within one (1) working day of the first occurrence)

- In accordance with appropriate techniques

- Applied by staff who have been trained and approved to use such techniques (42 CFR 482.356(a)(3)

- Implemented in the least restrictive manner possible (CFR 483.364(b)(2)

- In a room that is safe and sanitary, with adequate lighting, ventilation and temperature control

- Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the resident's condition (42 CFR 483.356(a)(3)(ii)

Prohibited Practices

- Restraint and seclusion must not be used simultaneously. (42 CFR 482.356(a)(4))

- Any personal or mechanical restraint of a resident in a face-down position is prohibited.

- Any personal or mechanical restraint of a resident in a "spread-eagle" (legs and arms apart) position is prohibited

- Standing or "as needed" (PRN) orders for seclusion or restraint are prohibited. (42 CFR 483.356(a)(2))

Procedure

Procedural Requirements

The following actions are required and must be documented for **any form of special procedure** with the exceptions as noted below. Refer to Provider Policy Manual Section 18.10 for Documentation Requirements policy.

- Only a physician or a PMHNP may order the seclusion or personal/mechanical restraint of a resident.

- If seclusion or personal/mechanical restraint is initiated without orders from a physician or PMHNP, a verbal or telephone order must be obtained from the physician or PMHNP by an RN or LPN (42 CFR 483.358(d)) and documented in the chart as soon as possible, but no later than one (1) hour after the start of the procedure. If the physician's or PMHNP's order cannot be obtained within the one (1) hour, the procedure must be discontinued.

- Pharmacological restraint may be initiated only by medical staff acting on a physician's or PMHNP's orders. At the time of the order, the physician or PMHNP must identify a specific time when the procedure is expected to end (i. e., the expected duration of the medication's effects), at which time the resident's condition will be assessed and the incident will be processed with the resident.

- The physician's or PMHNP's order for seclusion or personal/mechanical restraint may be for a time period not to exceed one (1) hour for residents younger than nine (9) years of age, or two (2) hours for residents nine (9) to twenty one (21) years of age. (42 CFR 483.358(e)) The original order may be renewed, if clinically justified, in accordance with these limits for up to a total of twenty four (24) hours. After the renewal limits of the original order are reached, a physician or PMHNP must see and assess the resident before issuing a new order.

- The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure. (42 CFR 483.364(a))

- The staff person responsible for terminating a mechanical restraint must be physically present throughout the duration of the procedure. (42 CFR 483.362(a))

- Within one (1) hour of the initiation of the emergency safety intervention, a physician, PMHNP or RN must conduct a face-to-face assessment of the physical and psychological well-being of the resident, to include but not be limited to the following:

    - The resident's physical and psychological status

    - The resident's behavior,

    - The appropriateness of the intervention measures

- Any complications resulting from the intervention. (42 CFR 483.358(f)) Even if the intervention is terminated in less than one (1) hour, the face-to-face assessment must be conducted within an hour of its initiation.

- The health and comfort of the resident must be assessed every fifteen (15) minutes by direct observation, and staff must record their findings at the time of observation.

- Vital signs must be taken every hour unless contraindicated and documented in the resident's record.

- There must be clear criteria for ending the special procedure (except for pharmacological restraint, which has an end-time identified by the physician or PMHNP), and the resident must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate.

- A physician, PMHNP, or RN must evaluate the resident's well-being immediately after the seclusion or restraint is terminated. (42 CFR 483.362(c))

- At an appropriate time, but no later than twenty-four (24) hours following the conclusion of the special procedure, the resident must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention. (42 CFR 483.370(a)) The goal is to enable the resident to understand the precursors to loss of control and to rehearse acceptable means of handling frustration and emotional distress.

- Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention, alternative techniques that might have prevented the use of the restraint or seclusion, the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion. (42 CFR 483.370(b))

- The PRTF must notify the resident's parent/guardian as soon as possible, but no later than twenty-four (24) hours after the initiation of any special procedure.

- If the resident's treatment plan does not already provide for the use of seclusion/restraint, then it must be amended or modified within one working day following the first use of any special procedure to reflect the use of that method as a part of the resident's treatment.

- A separate log documenting all occurrences of seclusion/restraint in the unit must be maintained.

- A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly.

- Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Records Content

The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about each resident. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. Clinical records must be complete, accurate, accessible and organized. Records must contain the following four (4) broad categories of information:

- **Administrative**: This portion of the record contains all information related to resident identification. It must include, at a minimum, a copy of the resident's birth certificate and/or social security card, a recent photograph of the resident, a copy of any legal documents verifying custody or guardianship of the resident when the responsible party is anyone other than the resident's legal parent(s). The name, address and phone number of the party bearing legal responsibility for the resident should be clearly identified, along with his/her relationship to the child, e.g. "mother", or "paternal aunt, legal guardian". If the resident is in the custody of the Department of Human Services (DHS), the county of custody should be specified and the caseworker identified as an agent of DHS, e.g. "Walthall County DHS, Susan Smith, caseworker."

- **Assessments**: This portion of the record contains information gathered through history taking, observation, testing and examination of the resident. It must include, at a minimum, those documents specified in Provider Policy Manual at Section 18.05 Assessment.

- **Treatment Planning**: This portion of the record contains the individualized interdisciplinary treatment plan, as well as all reviews and revisions. This section must meet the criteria specified in Provider Policy Manual Section 18.06 Treatment Planning. It should be noted that the treatment planning process is intended to take place in an interdisciplinary forum where many points of view may be expressed and consensus reached, rather than through a process of serial communication among professionals. Treatment planning documents should reflect the collaborative nature of the process.

- **Therapeutic Interventions:** All interventions attempted/provided during the course of the resident's treatment must be appropriately, accurately and legibly documented.

Psychotherapy

Essential elements that must be documented for each therapy session are as follows:

- The date and time of the session (time in and time out)
- The type of therapy (individual, family or group)
- The person(s) participating in the session
- The length of the session

- Clinical observations about the ~~child~~ resident (demeanor, mood, affect, mental alertness, thought processes, risks, etc.)
- The content of the session
- Therapeutic interventions attempted and the resident's response to the intervention(s)
- The resident's response to any significant others who may be present in the session
- The outcome of the session
- A statement summarizing the resident's degree of progress toward the treatment goals
- Periodic (at least monthly) reference to the resident's progress in relation to the discharge criteria and the estimated discharge date
- The signature (and printed name, if needed for clarity) of the therapist

Monthly summaries are not acceptable in lieu of psychotherapy session notes.

Milieu Therapy

Milieu Notes
Milieu notes must present a clear picture of the resident's participation and interactions in the therapeutic community. Milieu notes for each day should describe the resident's actions, staff interventions, and the resident's response to those interventions. Milieu notes are usually completed by direct care staff. If a checklist is used, it must be accompanied by at least a brief narrative. Milieu notes should be behaviorally focused. Behavior and events should be described rather than labeled. For example:

- Behavior labeled: Resident was oppositional
- Behavior described: Resident refused to make up bed when asked

Milieu notes should reflect a pattern of clear, respectful communication between staff and resident, with emphasis on the resident's involvement and collaboration in his/her own treatment.

Community Meeting Notes
Community meeting notes must be clearly identifiable. Each resident's participation must be documented (or his/her absence justified) in a minimum of one (1) community meeting per day. Notes must reflect that the community meetings are therapeutic in nature, i.e. that they address treatment issues such as problem identification, goal-setting, problem-solving, conflict resolution, behavioral observations/evaluation, problems in community living, etc. The nature of each resident's participation should be described. If a checklist is used, it must be accompanied by at least a brief narrative (i.e. more than he/she did not practice).

Medication

Medication is an important cornerstone of psychiatric treatment. Documents pertaining to this aspect of treatment (patient/family education and consent, medication orders, administration, monitoring) must be accurate and readily located. When medication is a prescribed intervention for a problem identified in the resident's treatment plan, it should be noted as such in the treatment plan. When medication changes

are made, they should be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes should be reviewed for all team members' update at the next available staffing opportunity.

Consent for Medication
When medications are prescribed or changed, a member of the professional staff will review with each resident's parent/guardian the following information:

- The name/class of medication
- The method of administration (oral, injection, etc.)
- The symptoms targeted
- Possible side effects of the medication
- Possible long-term effects of the medication
- Treatment alternatives
- Likely outcomes of using/not using the medication

When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference may be held by telephone, with the parent's/guardian's responses noted and dated. This form must be signed by the parent/guardian within thirty (30) days after the telephone consent. Two (2) PRTF staff must witness the form after talking with the parent/guardian.

Administration of Medication

Documentation must substantiate that medications have been accurately administered in accordance with the physician's or PMHNP's orders. Any variances must be justified in the record by medical staff.

Monitoring of Side Effects

An instrument for monitoring medication side effects will be identified and routinely administered to each resident who is prescribed psychoactive medication upon admission, at least every 60 days during his/her stay, and again at discharge.

Medication Adjustment vs. Pharmacological Restraint

The term **medication adjustment** is used to describe the use of a resident's routine medication *in a non-routine way* to help the resident through a period of heightened stress or agitation. This might involve ordering the administration of an extra dose (usually in a lower amount) of the same (or a similar, from the same class) medication that is already part of the resident's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the resident's treatment plan. Medication adjustment is not considered to be a special procedure. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the resident (and in some cases may be requested by the resident). Standing PRN orders for medication adjustments are acceptable.
The term **pharmacological restraint** refers to the use of a medication which is not a standard part of the

resident's treatment regimen to control or alter the resident's mood or behavior or to restrict his/her freedom of movement. Pharmacological restraint is considered to be a special procedure and special documentation is required (see section below). Standing PRN orders for pharmacological restraint are prohibited.

Adjunct Therapies

When other therapies are employed (art therapy, recreational therapy, occupational therapy, dance/movement therapy, music therapy, speech/language therapy), their use is documented in the clinical record in much the same manner as psychotherapy: date, length, type of session, together with a summary of the session's content, process, outcome and the therapist's name/signature.

Special Procedures

Seclusion/Restraint
Documentation of each incident of seclusion or restraint (personal, mechanical and pharmacological restraint) will include, but not be limited to, the following information:

- The date/time the procedure started and ended (42 CFR 483.358(h)(2)
- The name of the physician or PMHNP who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring it, and/or were responsible for terminating it (42 CFR 483.358(h)(5))
- Whether or not the resident returned from therapeutic leave within the preceding twenty four (24) hours
- The reason the procedure was used (42 CFR $83.358(h)(4))
- Which less restrictive options were attempted, and how they failed
- Criteria for ending the procedure (except for pharmacological restraint, when the end time is identified by the physician or PMHNP)
- The results of a face-to-face assessment conducted by a physician, PMHNP or RN within one (1) hour after initiation of the procedure to include (1) the resident's physical and psychological status, (2) the resident's behavior, (3) the appropriateness of the intervention measures and (4) any complications resulting from the intervention (42 CFR 483.358(f))
- The resident's condition at the time of each fifteen (15) 15-minute reassessment and at the end of the procedure
- The signature of the person documenting the incident
- A record of both debriefing sessions (staff/resident and staff only) which are required to take place within twenty-four (24) hours of the use of seclusion/restraint, to include the names of staff who were present for or excused from the debriefing and any changes to the resident's treatment plan that resulted from the debriefings. (42 CFR 483.370(c))

- Notification of the resident's parents/guardians within twenty-four (24) hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification. (42 CFR 483.366(b))

This documentation must be part of the resident's permanent record.

A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. (42 CFR 483.358(i)) A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly. These meetings must be documented.

Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Therapeutic Pass

A therapeutic pass consists of a resident's absence from the facility for less than eight (8) hours. If a resident leaves the facility on a therapeutic pass accompanied by PRTF staff, no documentation is required by DOM. If a resident leaves the facility on a therapeutic pass with anyone other than staff (e.g. relatives or representatives of DHS), therapeutic goals for the pass must be identified and documented. At the conclusion of the pass, documentation should indicate whether or not the therapeutic goals were met.

Therapeutic Leave

The attending physician or PMHNP must approve all therapeutic leave days. An absence from the facility of eight (8) or more hours between 12:01 a.m. and 11:59 p.m. on the same calendar day constitutes one (1) day of leave. Therapeutic leave is not allowed during the fourteen (14) day assessment period.

Documentation at the time a resident leaves the facility must include:

- The date/time of check-out
- The required time of return
- The name(s) of the person(s) with whom the leave will be spent
- The resident's physical/emotional condition at the time of departure (including vital signs)
- The types/amounts of medication being provided and instructions (in lay terms) for taking them
- Therapeutic goals for the leave. Goals must relate to the goals established in the treatment plan ("have time with the family" or "spend Christmas at home" is not considered a therapeutic goal)
- The name and signature of the person with whom the resident is leaving
- The signature of the staff person checking the resident out

Documentation at the time of the resident's return must include:

- The date/time of check-in
- The resident's physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint)
- Whether or not any contraband was found
- The types/amounts of medication being returned, if any, and explanation of any missed doses
- An explanation of any early or late return from leave
- A brief report on the outcome of the leave by the parent or guardian (were therapeutic goals achieved? Was the resident's behavior appropriate?)
- The name and signature of the person returning the resident's to the facility
- The signature of the staff person checking resident in
- An assessment of the outcome of the leave conducted by the resident's therapist within seventy two (72) hours of the resident's return from leave

Records Maintenance

Clinical records must be maintained for a period of five (5) years from the date of discharge. The facility must insure that the clinical record is not lost, destroyed or put to unauthorized use. The facility must insure the confidentiality of all information contained in the resident's record except when its release is authorized by the resident's parent/legal guardian or required by state or federal law.

When applicants are approved for PRTF admission by the Division's UM/QIO, they are authorized a limited number of days for that admission. It is the PRTF's job to help the resident accomplish treatment goals within that time frame or to justify to the UM/QIO why a longer stay should be authorized. When a longer stay is needed, it is the responsibility of the resident's attending physician to establish that the requirements for a continued stay have been met.

No later than seven (7) days prior to the end of a resident's authorized stay, the treatment team must have (a) developed a detailed discharge/aftercare plan for the resident or (b) applied to the UM/QIO for additional treatment time. In reviewing requests for extended treatment, the UM/QIO gives particular attention to:

- The appropriateness and quality of the resident's ongoing treatment as planned, provided, evaluated, revised and documented by the treatment team

AND

- Evidence that the resident's symptoms are still severe enough to require residential care.

When requests involve a continued stay beyond one hundred eighty (180) days, the UM/QIO will give close attention also to documented evidence that:

- The treatment provided during the previous one hundred eighty (180) days has been appropriate and has resulted in progress that is substantial, although insufficient for discharge,

- The reasons for the resident's insufficient progress have been explained adequately, and

- The treatment team has developed a new plan of treatment that plots a course towards discharge and includes a specific discharge target date.

When discharge problems arise because of the lack of an appropriate placement for the resident (ex: unsuitable family environment, foster home unavailability, no group home vacancies), it is the responsibility of the PRTF, together with the party having legal responsibility of the resident, to locate and/or arrange an appropriate placement. The lack of post-discharge options alone will not be considered a valid basis for continued PRTF stay.

Provisional Aftercare Plan

No later than seven (7) days prior to the resident's projected discharge date, the treatment team must develop a provisional aftercare plan for the resident. The plan's content will include, but not be limited to:

- The planned discharge date
- The date of the resident's admission and discharge
- The name of the person/agency expected to assume care and custody of the resident
- The physical location/address where the resident is expected to reside
- A list of the resident's psychiatric diagnoses
- Behavior management recommendations for parents and any other suggestions which might contribute towards the resident's successful participation in family life (e.g. use moderate voice tones as he is highly reactive to yelling; give simple instructions that involve not more than one or two steps; give only one verbal redirection before assigning consequences for behavior; she needs a full nine (9) hours of sleep in order to function well the next day; identify a behavioral goal at the beginning of each day and evaluate each evening; etc.)
- Educational summary and practical recommendations/suggestions for teachers which might contribute towards the resident's success at school (e.g. place the resident at the front of the class; assign study partners; eliminate visual distractions; allow verbal test-taking, etc.),
- Treatment recommendations or observations/comments for follow-up mental health clinicians which may increase the likelihood of success in therapeutic aftercare (e.g. leaving some time at the end of a family session for resident to process individually was helpful; in family therapy, resident responded better in sub-groupings than when the whole family met together; resident may be exceptionally cautious about trusting a new therapist; resident might work better with a female than with a male therapist; resident would benefit from participation in a social skills group with peers; etc.)

Final Aftercare Plan

At the time of the resident's discharge from the facility, the provisional aftercare plan will be amended to include:

- The dates of the resident's admission and discharge
- The name of the person/agency expected to assume care and custody of the resident
- The physical location/address where the resident is expected to reside
- A list of the resident's psychiatric diagnoses

- Detailed information about the resident's medications: the names, strengths and dosage instruction (in lay terms) for all medications prescribed for the resident, as well as any special instructions such as lab work requirements

- Behavior management and other pertinent recommendations for parents/caregivers; these should be carried over, though perhaps altered or expanded, from the provisional plan

- The names, addresses and telephone numbers of the agencies/persons who will provide follow - up mental health services, the date and time of initial aftercare appointments, and treatment recommendations for the providers of those services

- The place where the resident will be attending school, a summary of the resident's educational progress while at the PRTF, his/her current educational standing, and recommendations for the resident's teachers; it may be advisable for the educational component of the aftercare plan to be organized as a stand-alone section, since it (but NOT the full plan) is required to be mailed to the resident's school

- Other recommended resources, if applicable, e.g. recreational, rehabilitative, or other special programs believed to offer benefit to the resident

- The parent/guardian's signed acknowledgment that s/he was provided:

    - A copy of the resident's aftercare plan

    - A minimum of a seven (7) day supply of the resident's medications

    - Prescriptions for a thirty (30) day supply of the resident's medications.

Discharge

At the time of the resident's discharge from the facility, the PRTF will provide the parent/guardian with

- A written copy of the final aftercare plan,

- A supply of all current medications prescribed for the resident, equal to the amount already stocked for that resident by the PRTF but not less than a seven (7) day supply or more than a thirty (30) day supply

- Prescriptions for a thirty (30) day supply of all medications prescribed for the resident

The PRTF will seek the parent's/guardian's consent to release copies of the resident's educational summary and recommendations to the resident's school. If this consent is obtained, the educational information must be mailed to the resident's school within one working day following the resident's discharge. The school should not be sent the resident's complete aftercare plan, but only the part pertaining to education.

The PRTF will seek the parent's/guardian's consent to release copies of the resident's aftercare plan and discharge summary to the providers of follow-up mental health services. If this consent is obtained, the aftercare plan and discharge summary must be mailed to mental health aftercare within two (2) weeks following the resident's discharge.

All PRTF's are required to maintain resident fund accounts, if requested by a resident or the resident's legal guardian. This section describes the procedures that must be followed in maintaining these accounts.

DOM has a program of on-site resident fund account audits in all facilities participating in the program. The purpose of the program is to assure compliance with federal regulations and DOM policy and to assist facilities in devising acceptable systems of accounting for resident funds.

Statement Provided at Time of Admission

The facility must provide each resident and/or the resident's legal guardian with a written statement at the time of admission that states the following:

- All services provided by the facility which are included in the facility's basic rate
- There is no obligation for the resident to deposit funds with the facility
- The right to select how personal funds will be handled. The following alternatives must be included:
    - The right to receive, retain and manage his/her personal funds or have this done by a legal guardian, if any
    - The right to apply to the Social Security Administration to have a representative payee designated for the purpose of federal or state benefits to which he/she may be entitled
    - The right to designate, in writing, another person to act for the purpose of managing his/her personal funds; and
    - The facility is required to hold, safeguard and account for such personal funds under a system established and maintained by the facility in accordance with DOM policy if requested by the resident's legal guardian.
- Any charges for this service are included in the facility's basic rate;
- The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident's legal guardian.

Basic Requirements

The facility must, upon written authorization by the resident's legal guardian, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services but must include any charges in the facility's basic daily rate.

Individual Resident Fund Records

The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must keep these records in accordance with the American Institute of Certified Public Accountant's Generally Accepted Accounting Principles, and the records must include at least the following:

- Resident's name
- Identification of resident's legal guardian
- Admission date
- Date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction
- Receipts indicating the purpose for which any withdrawn funds were spent; and resident's earned interest, if any

A written authorization form must be kept on file for the following disbursements:

- Items and services charged by the facility and requested by a resident, such as telephone, television, private room, and privately hired nurses or aides, etc.
- Beautician or barber charges
- Pharmacy charges and pharmacy freedom of choice

A facility must provide all residents with freedom to use the pharmacy of their choice for all drugs not reimbursed through the PRTF per diem rate. The pharmacy must, however, meet facility guidelines for drug labeling and packaging in an effort to reduce or eliminate medication errors. The standard pharmacy services authorization form used by the facility must not list the name of any pharmacy preferred by the facility. The form must leave a blank for the name of the chosen pharmacy to be written by the resident or his or her responsible party.

Access to Resident Fund Records

The facility must provide each resident's legal guardian reasonable access to the resident's financial records.

Quarterly Statements

The facility must provide a written statement, at least quarterly, to each resident's legal guardian. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account. The statement must include at least the following:

- Balance at the beginning of the statement period
- Total deposits and withdrawals
- Interest earned, if any

- Identification number and location of any account in which that resident's personal funds have been deposited

- Ending balance

Co-Mingling of Resident Funds

The facility must keep any funds received from a resident, for holding, safeguarding and accounting, separate from the facility's funds and from the funds of any person other than another resident in that facility.

Deposit of Resident Funds

The facility must deposit any resident's personal funds in excess of $50.00 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts. The interest bearing account must earn interest on any balance amount in the account. The facility must credit all interest earned, whether individual resident's funds are greater or lesser than $50.00, on such separate account (or accounts) in one of the following ways, at the election of the facility:

- Pro-rated to each resident on an actual interest-earned basis;

OR

- Pro-rated to each resident on the basis of his/her end-of-quarter balance.

The facility may maintain a resident's personal funds that do not exceed $50.00 in a non-interest-bearing account, a petty cash fund or in an interest-bearing account.

Access to Funds

- Funds held in the facility:
  The resident must have access to funds daily, at least two (2) hours during normal business hours and for some reasonable time on Saturdays and Sundays. The facility must, upon request or upon the resident's transfer or discharge, return to the resident's legal guardian all funds remaining that the facility has received for holding, safeguarding and accounting and that are maintained in a petty cash fund.

- Funds held outside the facility:
  For a resident's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request or upon the resident's transfer or discharge must, within (30) days, return to the resident's legal guardian all funds held outside the facility.

Accounting Upon Change of Ownership

- **Duties to new owner:**
  Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountant's Generally Accepted Accounting Principles, of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

- **Duties to resident:**
  The facility must give each resident's legal guardian a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

- **Rights of resident:**
  In the event of a disagreement with the accounting provided by the facility, the resident and/or the resident's legal guardian retains all rights and remedies provided under state law.

- **Sponsor signatures for fiscal responsibility:**
  A PRTF must not require a third party guarantee of payment of the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the PRTF may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

- **Deposit:**
  A PRTF cannot require a deposit before admitting a Medicaid-eligible resident.

Surety Bond

The facility must purchase a surety bond or provide assurance to guarantee the security of all personal funds deposited with the facility. The surety bond is the commitment of the facility in an objective manner that the facility will hold, safeguard, manage and account for the funds residents have entrusted to the facility. The facility assumes the responsibility to compensate the obligee for the amount of the loss up to the entire amount of the surety bond.

Reasonable alternatives to a surety bond must:

- Designate the obligee (the residents individually or in the aggregate) who can collect in case of a loss

- Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the resident's funds

- Be managed by a third party unrelated in any way to the facility or its management

The facility cannot be named as a beneficiary. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entities, are not acceptable alternatives.

If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the resident's in the corporation's facilities are covered against any losses due to acts or errors. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the resident's in the corporation's facilities would be protected.

Resident Property Records

The facility must maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the facility by the resident. The property record must be available to the resident and the resident's legal guardian.

Notice to Certain Balances

The facility must notify each resident's legal guardian receiving medical assistance under Title XIX when the amount in the resident's account reached $200 less than the SSI resource limit for one person. The notice must include the fact that if the amount in the account (in addition to the value of the resident's other non-exempt resources) reaches the SSI resource limit for one person, the resident may lose

eligibility for such medical assistance or SSI.

The facility must notify the appropriate Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the SSI resource limit for one person.

Cost Reports

All facilities must submit a cost report, in duplicate, on or before the last day of the fifth (5th) month following the close of the reporting period. When the date of the cost report falls on a Saturday, Sunday, state or federal holiday, the cost report is due on the following business day. All PRTFs must file cost reports based on a standard year end as prescribed by the State Plan unless otherwise approved by the DOM. State owned facilities must file cost reports based on a June 30 year end. County owned facilities must file cost reports based on a September 30 year-end. All other facilities must use a standard year-end of December 31. Facilities may request to change to a facility specific cost report year-end, if the requested year-end is the facility's Medicare or corporate year-end. Cost reports must be prepared in accordance with the State Plan for reimbursement of Psychiatric Residential Treatment Facilities that is found in the Long Term Care State Plan. A copy of the Plan is available upon written request or on the DOM web site.

Cost reports that are either postmarked or hand delivered after the due date or extended due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. Providers that do not file a required cost report within six (6) months of the close of the reporting period will have their Medicaid Provider Agreement terminated.

Facilities beginning operations during a reporting year will prepare a cost report from the date of certification to the end of the sixth (6th) month of operation. Facilities will be paid the maximum rate for their classification until the six (6) month cost report is received and the rate is recalculated. A retroactive rate adjustment will be made based on the six month cost report effective the date of certification.

Facilities that undergo a non-related party change of ownership must file a cost report from the date of the change of ownership through the end of the third (3rd) month of ownership. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. Pending receipt of a cost report, the new facility will be paid the base rate of the prior owner, excluding hold harmless payment and return on equity. The provider may request and, absent any good cause to deny, the executive director shall approve setting the new owner's interim rate using the maximum class per diem rate. Upon receipt of the three (3) month cost report, a per diem rate will be established based on a desk review and will be effective retroactive to the first day of certification.

Field Review of Facility Cost Reports

The Division of Medicaid conducts periodic field level cost report financial reviews of selected facilities to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. The reviewers will include those persons engaged by the Division of Medicaid to conduct the reviews including, but not limited to, Division staff and contract personnel. As necessary, adjustments will be made to the cost reports reviewed based on the results of the reviews. Each adjustment will include a written description of the adjustment being made including the reason for and amount of the adjustment.

Retention of Records

Providers must maintain adequate documentation, including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program. The cost report must be based on the documentation maintained by the facility. All non-governmental facilities must file

cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting.

Financial and statistical data must be current, accurate and in sufficient detail to support costs contained in the cost report. This includes ledgers, books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, basis for allocating costs, etc.) that pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, room numbers of residents, hospital leave days and therapeutic leave days.

Documentation should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant changes is made to the Division of Medicaid. This disclosure should be made as a footnote on the cost report and should include the effect(s) of the change. All documentation, including cost reports, must be maintained for a period of three (3) years after submission to the Division of Medicaid.

Providers must make available to the Division of Medicaid all documentation that substantiates the costs included in the facility cost report for the purpose of determining compliance with Medicaid policy. These records shall be made available as requested by the Division of Medicaid. All documentation, which substantiates the information, included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division. If the Division of Medicaid reviewers are required to travel out of state to conduct any part of the cost report review, the provider shall bear all expenses and costs related to this travel, including, but not limited to, travel and reasonable living expenses. Such expenses and costs will not be allowable on any subsequent cost reports.

Work Space

The provider is required to make available to the Division of Medicaid reviewers adequate work space and privacy at the appropriate location to conduct the review.

Rate Setting

DOM uses a prospective method of reimbursement. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits. Standard rates will be redetermined annually in accordance with the Medicaid State Plan. In no case may the reimbursement rate for services provided under this manual exceed an individual facility's customary charge to the general public for such services in the aggregate except for those public facilities rendering such services free of charge or at a nominal charge.

DOM may adjust prospective rates pursuant to changes in federal and/or state laws or regulations. All Plan changes must be approved by the federal grantor agency. Based on allowable and reasonable costs, DOM establishes per diem reimbursement rates for each facility. Each facility is furnished a copy of Attachment 4.19-D of the State Plan that is also known as the Long-Term Care Reimbursement Plan. For additional information regarding PRTF's rate computation, contact the Bureau of Reimbursement at the Division of Medicaid.

Services and Charges

The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan. While the facility may set their basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate. Any items and services available in the facility that are not covered under the Title XVIII or the facility's basic per diem

rate or charge must be available and priced identically for all residents in the facility.

Payment during Admission and Discharge from the Facility

DOM allows payment for the date of admission to the PRTF. DOM does not cover the date of discharge from the facility. If a resident is discharged on the date of admission, the day will be covered as the date of admission. A Medicaid-eligible resident must not be charged for the date of discharge.

Private Room Coverage by Medicaid

The overall average cost per day determined from the cost report includes the cost of private rooms. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in our reimbursement rates and no extra charge will be made to the resident, his/her family or the Medicaid program. In accordance with 42 CFR 447.15, the Medicaid reimbursement will be considered as payment in full for the resident.

Hospital Leave

The following rules apply to hospital leave:

- A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed may not be filled with another resident during the covered period of hospital leave.

- A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

- Facilities may not refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

Elopement

If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the 24 hours, then the child/adolescent must go through a readmission process.

Payment During Therapeutic Leave from the Facility

A temporary absence of a resident from a PRTF will not interrupt the monthly payments to the facility under the provisions as outlined below. The period of leave will be determined by counting, as the first day of leave, the day the resident left the facility. Each facility is required to maintain leave records and indicate periods of therapeutic leave days. Before a resident departs on therapeutic leave, the facility must provide written information to the resident and family member or legal representative explaining leave policies. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility.

The following rules apply to therapeutic leave:

- An absence from the facility for eight (8) hours or more within one calendar day the following day constitutes a leave day.
- Medicaid coverage of therapeutic leave days per fiscal year (July 1 to June 30) for a PRTF is eighteen (18) leave days.
- Each therapeutic leave day taken each month must be reported on the billing mechanism.
- The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of the leave, who participated in the leave, and the outcome of the leave. Refer to Provider Policy Manual Section 18.10 for Documentation Requirements policy.

A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

Termination of a Provider Agreement

When a provider agreement is TERMINATED, federal regulations provide that payments may continue for up to thirty (30) days to provide time for an orderly transfer of Medicaid residents. The facility must notify all Medicaid residents, families, and/or guardians in writing within forty-eight (48) hours of receipt by the facility of the decertification letter. The facility must also submit to DOM a current list of Medicaid residents along with the name, address and telephone number of the family and/or guardian and the resident's attending physician. Medicaid staff will also notify the resident's families and/or guardians and can assist both the families and the facility in making other living arrangements for the resident.

The Medicaid Regional Offices are responsible for determining Medicaid eligibility for individuals in residential care with the exception of those beneficiaries who continue to receive Supplemental Security Income (SSI) while residing in a Title XIX medical facility. The Social Security Administration determines eligibility for these individuals.

The Medicaid Regional Office that serves the area of the resident's legal address is responsible for authorizing Medicaid reimbursement payments via Form DOM-317 for each Medicaid beneficiary, including SSI beneficiaries.

Form DOM-317 documents the most recent date of Medicaid eligibility and the amount of Medicaid income due from the beneficiary each month. Medicaid income is the amount of money the resident must pay toward the cost of his/her care.

Refer to Provider Policy Manual Section 3.0 for Beneficiary Information policies.

If a resident is Medicaid eligible upon entry to a PRTF, then no DOM-317 form will be required as long as the resident remains eligible during the admission. If a resident is not Medicaid eligible upon entry or if eligibility ends during the admission, a DOM-317 form is necessary in order to initiate the application process in the Medicaid Regional Office. The resident must be determined eligible under an available coverage group described in the eligibility section. Refer to Provider Policy Manual Section 3.0 for Beneficiary Information policy.

The DOM-317 is used by the PRTF and the Medicaid Regional Office as an exchange of information regarding beneficiaries of Medicaid. The purpose of this form is three-fold:

- It is initiated by the PRTF at the time a Medicaid applicant/beneficiary enters, transfers in or out, or is discharged
- It is generated from the regional Medicaid Regional Office at the time an applicant has been approved for Medicaid and will notify the facility of the effective date of Medicaid eligibility and the amount of the beneficiary's Medicaid income
- It will also be used to notify the PRTF of any change in Medicaid income which occurs or if Medicaid is terminated or denied

General Instructions

The PRTF originating the form will prepare an original and one (1) copy. The original is to be mailed to the Medicaid Regional Office that serves the beneficiary's county of legal residence while the copy is retained by the facility.

The Medicaid Regional Office will respond with a computer-generated form that results from input of information from the originating form. DOM-317A forms are generated by the Medicaid Regional Office to report the status of an application or a review of eligibility. Retain the DOM-317A in the resident's file.

PRTF providers should contact the following areas with questions:

ISSUE	CONTACT/ POSITION
Program Information	Division Director, Mental Health Programs
Provider Enrollment	Division Director, Provider Relations
On-Site Compliance Review and CAP Approval	Division Director, Mental Health Programs
Cost Reporting	Bureau Director, Bureau of Reimbursement
Appeals Process (UM/QIO Certification)	Bureau Director, Bureau of Policy
Appeals Process (PRTF Status Ruling; CAP Approval)	Division Director, Mental Health Programs Bureau Director, Bureau Mental Health Programs Deputy Administrator, Health Services Executive Director, Division of Medicaid
DOM Telephone Information	601-359-6050

Correspondence should be addressed to the appropriate bureau or division at the following address:

Division of Medicaid
550 High Street
Walter Sillers Bldg., Suite 1000
Jackson, MS 39021

Reporting Requirements

The PRTF is required to keep DOM informed of changes in key staff as well as serious occurrences involving residents of the PRTF. Information regarding the time frames and methods of reporting for each situation is provided in the following table.

Staff changes which must be reported to DOM are changes in PRTF Administrator, Medical Director or Clinical Director. Notification should be sent as soon as possible, but no later than seventy two (72) hours following the effective date of the change.

The death of ANY resident or a serious incident involving ANY resident, regardless of whether or not those involved were Medicaid beneficiaries, must be reported to DOM. If Medicaid beneficiaries were involved, their names should also be provided as a part of the report.

Serious incidents are defined as:

- Serious injury of a resident, defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. All serious injuries that require medical intervention are to be reported;
- Suicide attempt by a resident;
- Elopement of a resident;
- Allegations of sexual contact between residents
- Allegations of maltreatment (abuse/neglect) of a resident;
- Any injury of a resident sustained in the course of a seclusion or restraint.

Any death of a resident should be reported to DOM by telephone as soon as possible (but no later than close of business the same day), with a follow-up written report faxed by the close of business the following day. Reports made for any other reasons should not be phoned in, but should be submitted by fax in the time frame indicated.

Each report should include:

- The name of the resident, if she/he is a Medicaid beneficiary;
- A description of the occurrence; and,
- The name, street address, and telephone number of the facility.

Some reports are required to be submitted to other agencies or entities in addition to DOM. These are indicated in the table below as DHS (Department of Human Services), MSDH (Mississippi State

Department of Health, Bureau of Health Facilities Licensure and Certification), P&A (the state Protection & Advocacy office), CMS (the regional office of the Center for Medicare/Medicaid Services), MFCU (Medicaid Fraud Control Unit, Attorney General) and the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.

Refer to the table on the following page.

EVENT	PARENT	DOM	DHS	MSDH	P&A	CMS	QIO	MFCU
Death	ASAP, but within 24 hrs	Phone ASAP, but by COB same day; follow-up Fax by COB next day		Within 24 hrs	Within 24 hrs	Within 24 hrs	Within 24 hrs	Within 24 hrs
Serious Injury	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs	Within 24 hrs		Within 24 hrs	Within 24 hrs
Suicide Attempt	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs	Within 24 hrs		Within 24 hrs	Within 24 hrs
Elopement	ASAP, but within 24 hrs	Fax only, by COB same day		Phone , within 24 hrs; follow-up in writing within 72 hrs			By COB same day	Within 24 hrs
Allegations of sexual contact between residents	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs			By COB next day	Within 24 hrs
Allegations of maltreatment (abuse/neglect) of resident	ASAP, but within 24 hrs	Fax only, by COB next day	By COB next day	Phone , within 24 hrs; follow-up in writing within 72 hrs				Within 24 hrs
Any injury in the course of seclusion or restraint	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs				Within 24 hrs
Staff changes of Administrator, Medical or Clinical Director		Fax only, w/in 72 hrs of change		Phone , within 24 hrs; follow-up in writing within 72 hrs				

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:
Section: Mental Health/Psychiatric Residential Treatment Facility (PRTF) Subject: Reserved for Future Use	Section: 18.19-18.29 Pages: 1 Cross Reference:

Sections 18.19-18.29 are RESERVED FOR FUTURE USE.

Purpose and Goals

The purpose of an on-site compliance review is to verify that the PRTF is in compliance with applicable state and federal requirements for mental health treatment and to monitor the quality of treatment being provided to Medicaid beneficiaries.

The goals of the OSCR are:

- To assess the program and services offered by the PRTF through direct observation, document review and staff/resident interviews by experienced clinicians, and
- To provide clear, specific feedback regarding review findings to PRTF staff in order that services may be enhanced

Review Team Composition

The review team will comprise at least two (2) but no more than five (5) DOM staff and consultants, including an identified team leader, who will be a full-time DOM staff person. The team members may include:

- DOM representatives
- A registered nurse
- A licensed certified social worker
- A licensed psychologist
- A board-certified child/adolescent psychiatrist, a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, or a psychiatric mental health nurse practitioner (PMHNP)

When a follow-up review is concerned with previously identified problems that are medical in nature, one team member will be a psychiatrist, PMHNP or registered nurse.

Pre-Review Notification

Written notification of an upcoming OSCR will be provided to the PRTF administrator twenty-four (24) to forty-eight (48) hours prior to the time the OSCR is scheduled to begin. The notification will include:

- The anticipated schedule for the OSCR
- The names of the participating team members
- A list of documents to be reviewed
- A list of clinical records to be reviewed

Upon receipt of its pre-review notification, the PRTF will contact DOM to verify awareness of the upcoming OSCR.

Overview of OSCR Process

The OSCR process is intended to monitor a PRTF's overall operations for compliance with legal requirements and for quality of clinical programs and services. The review inquires into the PRTF's operations in three domains:

- **Administration**: This area comprises the organizational structure and management of the facility. The facility's administrative functioning is evaluated through the review of such information as policy and procedure manuals, staff credentials, transfer agreements with hospitals, utilization review documents, incident reports, etc. The team will also check for equity of treatment application for Medicaid beneficiaries vs. non-beneficiaries. The administrative area will account for fifteen percent (15%) of the PRTF's overall compliance rating.

- **Program**: This area comprises the philosophy and structure of the facility's approach to treatment (what the facility believes constitutes good treatment and how they plan to carry it out). The facility's program is evaluated through the review of documents (e.g. policy and procedure manuals, unit rules/regulations, unit level systems, schedules of unit activities, staff training schedules and agendas, seclusion/restraint logs, etc.), the facility tour, and staff interviews. The program area will account for thirty-five percent (35%) of the PRTF's overall compliance rating.

- **Services:** This area comprises the manner in which a PRTF's program translates into treatment of individual residents. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each child. The facility's services are evaluated through the review of clinical records and resident interviews. The services area will account for fifty percent (50%) of the PRTF's overall compliance rating.

The frequency with which routine reviews are scheduled is dependent upon the status of the facility at the time of its last review. Generally, the higher the facility's rating, the longer the period of time between reviews. Refer to the PRTF Status Categories below for applicable time frames. Routine OSCRs will almost always be full-scale reviews, with every aspect of the PRTF being evaluated (refer to Provider Policy Manual Sections 18.31 through 18.36 for review criteria). In most cases, a routine OSCR will be completed in two (2) to three (3) days.

At the discretion of DOM, an OSCR may be conducted as a partial off-site (review of records) and partial on-site (facility tour and staff/resident interviews) compliance review.

Regardless of when the next routine OSCR may be due, an interim review may be scheduled at any time at the discretion of DOM to address specific concerns. Interim reviews may be full-scale or partial, depending upon the focus or scope of DOM's concerns. Interim reviews will typically be completed in one (1) to three (3) days.

General Outline of OSCR Process

- **Entrance Interview:** At the beginning of the OSCR, the review team will meet with a small group (not to exceed six (6) people) of PRTF staff selected by the facility for an overview of the OSCR process. The group will typically consist of the PRTF Administrator, Medical Director, Clinical Director, and one representative each from nursing, primary therapy and direct care staff. The entrance interview is the facility's opportunity to meet the review team and inform the team of any changes, improvements, etc. that have occurred since the last review or to ask questions about the current proceedings. This phase typically will last thirty (30) minutes or less.

- **Tour of the Facility:** The review team will tour all units of the PRTF and talk informally with staff and/or residents. They will note the physical layout and appearance/atmosphere of the units, review posted information, and observe interactions between staff and residents. Team members may ask to sit in on community meetings or group therapy sessions for additional insight into service delivery. Refer to Provider Policy Manual Section 18.31 for CRI-Administrative Section: Document Review policy.

- **Review of Administrative and Program Records:** A review team member, usually the team leader, will review documents requested in the pre-OSCR notification. Information requested may include (but is not limited to) records pertaining to staff credentials, policy and procedure manuals, transfer agreements with hospitals, utilization review, staff training schedules and/or agendas, seclusion/restraint logs, treatment outcome data, etc. In addition, the facility must provide the review team with a roster of all staff who provide direct services to resident. The roster should be organized according to discipline and each name should be accompanied by the staff member's signature. All documents requested should be ready for review at the beginning of the OSCR. Refer to Provider Policy Manual Sections 18.32 for CRI- Program Section A: Facility Tour policy and 18.33 CRI-Program Section B: Document Review policy.

- **Review of Clinical Records:** Randomly selected resident records will be reviewed by the team to assess compliance with PRTF treatment requirements identified by DOM policy. Charts will be selected from the census list of residents served since the last OSCR. A minimum of five (5) charts or five percent (5%) of the total census since the last review, whichever is greater, will be selected. The chart list will include at least one (1) resident who was admitted since the last review, one (1) resident who was discharged since the last review, and at least three (3) others drawn from the census at large. The PRTF must provide the review team with an organization guide to the resident record which clearly identifies where specific documents may be found within the record. Refer to Provider Policy Manual Section 18.35 for CRI-Clinical Services Section A: Resident Record Review policy.

- **Staff Interviews:** Staff to be interviewed will be identified as early in the review process as possible. When interviewing staff, review team members will want to know whether or not there are guiding treatment principles of which ALL STAFF (from psychiatrist to cafeteria worker to therapist to resident aide to facility administrator to maintenance worker) are aware and to which ALL STAFF adhere. The team is particularly interested in how well program guidelines are carried out in practice and whether or not staff work together collaboratively, functioning as a true team. Refer to Provider Policy Manual Section 18.34 for CRI-Clinical Services Section C: Staff Interviews policy.

- **Resident Interviews:** Residents to be interviewed will be identified as early in the review process as possible. When interviewing residents, review team members will want to know whether or not residents feel they are active participants in their treatment, how knowledgeable they are about specific aspects of their treatment programs, and how they view the program and staff's ability to help them. Refer to Provider Policy Manual Section 18.36 for CRI-Clinical Services Section B: Resident Interviews policy.

- **Review Team Conference:** At the conclusion of the above components, the review team will meet *in camera* to compile all information acquired and prepare for the Exit Interview.

- **Exit Interview:** The review team will meet with the PRTF staff (the same representatives who were present at the Entrance Interview unless changes have been discussed with the review team leader) to present an overview of the team's findings and inform the PRTF of its current status. At this time, PRTF staff may ask questions, request examples of problems cited, etc. This phase typically will last one (1) hour or less.

- **Written Report:** The DOM will provide the PRTF with a written report of the review team's findings at the conclusion of the OSCR unless the facility's status is deferred or there are extenuating circumstances which preclude the provision of a written document at that time.

PRTF Status Categories

At the time of the Exit Interview, the PRTF will be informed of its status ruling if that can be clearly determined. The rating categories are as follows:

- **Commendation:** Program and services consistently exceed standards. No problems were cited by the review team. The next OSCR will be scheduled within the next two (2) years.

- **Approved:** Program and services consistently meet standards. No problems were cited by the review team. The next OSCR will be scheduled in one (1) to two (2) years.

- **Review:** Overall program and services are of acceptable quality with one (1) or more specific areas of substandard quality. If there were no citations, the next OSCR will be scheduled in nine (9) to fifteen (15) months. If problems were cited, a CAP must be submitted to address them. The next OSCR will be scheduled within the next six (6) to twelve (12) months after the implementation of an approved CAP.

- **Probation:**

  - Program and services are of substandard quality ***OR***

  - The facility is already on Review Status and failed to show improvement in a follow-up OSCR. ***OR***

  - Conditions exist which could jeopardize the safety or well-being of residents.

  A CAP must be submitted to address all problems cited in the review. The next OSCR will be scheduled within the next three (3) to six (6) months after implementation of an approved CAP.

- **Suspension:** Program and services are of unacceptable quality **OR** conditions exist which jeopardize the lives or well-being of residents OR the facility received probation status in two (2) consecutive OSCR's and failed to show sufficient improvement in the next follow-up OSCR. Admissions of Medicaid beneficiaries are suspended until further notice. The next OSCR will be

scheduled as soon as reasonably possible (no later than thirty (30) days) after the implementation of an approved CAP.

- **Deferred:** If the review team requires additional information or expert opinion in order to complete its determination, then the status ruling may be deferred. In cases of deferred status, the DOM must recontact the PRTF within ten (10) days and

  - Request additional information or documentation, which must then be provided by the PRTF within ten (10) days of receiving the request ***AND/OR***

  - Schedule a continuation of the OSCR, in which case additional team members may participate in further on-site review of the facility ***OR***

  - Submit a final status ruling.

  The ten (10) day request/submission response cycle will continue until a final status determination is made.

Corrective Action Plan (CAP)

Any facility receiving a rating of Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by DOM no later than ten (10) working days following the PRTF's receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific actions that will be taken to correct each identified problem
- Specifying an implementation date for each corrective action
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc.

Justifications or explanations for the cited problems have no place in the CAP. Although there may be good reasons for the existence of the problems, DOM is interested only in the proposed solutions. The narrative of the CAP should be succinct and to-the-point. The following format is suggested for each separate element cited:

- Description of element
- Findings
- Plan of correction
- Implementation date
- Supporting documentation (attached to the CAP and referenced in the narrative response)

Examples:

- Description of element: Psychosocial assessment contains a developmental profile.
- Findings: Developmental profiles were missing from two (2) of the charts reviewed, were

inadequate or incomplete in two (2) others.

- Plan of correction: Program Director will provide in-service training to therapy staff on developmental history-taking and documentation. Psychosocial assessments will be reviewed for completeness through record audits by Program Director.

- Implementation Date: January 1, 2008.

- Supporting documentation: Attachment A: Training logs.

The CAP will include the name and telephone number of a PRTF staff member who will work with DOM towards approval of the CAP.

The DOM must approve/disapprove of the PRTF's proposed CAP within ten (10) working days of its receipt by DOM. The ten (10) day submission/ ten (10) day response cycle will continue until DOM approves a CAP. The PRTF must implement the CAP within thirty (30) days of its approval. When notifying the PRTF of its CAP approval, the DOM will also inform the PRTF of the anticipated time of the next follow-up OSCR.

Appeals Process

If the PRTF disagrees with its status ruling or has a complaint regarding DOM's response to its proposed CAP, it may appeal the review team's findings. The facility's appeal must be received in writing by DOM within ten (10) days of the date of the final status determination or within ten (10) days of DOM's response to the proposed CAP. The working documents from the review will be destroyed thirty (30) days after the approval of the CAP. The facility should address its concerns to:

Division Director, Mental Health Services
Bureau of Mental Health Programs
Division of Medicaid

If the PRTF disagrees with the response to its appeal, it should address its concerns to:

Bureau Director, Mental Health Programs
Division of Medicaid

If the PRTF disagrees with the results of this appeal, it should address its concerns to:

Deputy Administrator, Health Services
Division of Medicaid

If the PRTF disagrees with the results of this appeal, it should address its concerns to:

Executive Director
Division of Medicaid

PRTF COMPLIANCE REVIEW INSTRUMENT (CRI)
Administrative Section: Document Review

Reviewer's Name: _____

RATING SCALE: 4 – Exceeds Standards 3 – Meets Standards 2 – Sub-standard 1 – Unacceptable
Y – Yes N – No

Element	Rating	Comments
1. The facility is COA or JCAHO-accredited.	Y N	
2. The facility's PRTF license is current.	Y N	
3. The licenses of professional staff are current.	Y N	
4. A roster of all staff, divided by discipline, who provide direct services to residents were provided, with staff signatures.	Y N	
5. The facility meets staffing requirements established by DOM.	Y N	
6. The facility has informed DOM of changes in PRTF administrator, Medical Director, or Clinical Director within 72 hours of the effective date of the change.	Y N N/A	
7. Records and documentation requested by DOM were provided at the times requested. An index or key was provided to locate required information.	Y N	
8. The facility's policy and procedures are in accordance with DOM requirements.	Y N	
9. Documentation indicates that the facility follows its policy and procedures in practice.	Y N	
10. The facility's policy and procedures for transfer, discharge and provision of services are the same for all residents, regardless of payment source.	Y N	
11. The facility does not accept new residents who have attained the age of 21 or maintain residents who have attained the age of 22.	Y N	

12. When an applicant is denied admission, the facility informs the referral source of the reason for the denial within 72 hours.	Y N N/A	
13. The facility has a signed transfer agreement with one or more general hospitals to provide needed diagnostic and medical services to residents.	Y N	
14. The facility has arrangements with community physicians to provide specialized medical care to residents when needed.	Y N	
15. Personnel records verify that RN's and LCSW's who participate in treatment planning have a minimum one year's experience in treating children with SED.	Y N	
16. The facility has informed DOM in writing of the occurrence of any serious incidents as defined in Section 18.18 within one working day following their occurrence. If Medicaid beneficiaries are involved, their names are provided as part of the report.	Y N N/A	
17. Records and documentation are maintained for a period of 5 years.	Y N	
18. The facility has an up-to-date copy of Medicaid Provider Policy Manual, Section 18.	Y N	

PRTF COMPLIANCE REVIEW INSTRUMENT (CRI)
Program Section A: Facility Tour

Reviewer's Name: _____

RATING SCALE: 4 – Exceeds Standards 3 – Meets Standards 2 – Sub-standard 1 – Unacceptable
Y – Yes N - No

Element	Rating	Comments
1. The physical treatment environment is		
a. Attractive (clean, pleasant decor)	4 3 2 1	
b. Warm, child-friendly (pictures, plants, home-like atmosphere)	4 3 2 1	
c. Treatment-oriented (educational/motivational posters, treatment reminders).	4 3 2 1	
2. A condensed, quick-reference version of the behavior program is posted on the unit in a format that makes it easily accessible and highly visible to residents.	Y N N/A	
3. Unit rules and activity schedules are:		
a. Posted on the unit in a format that makes them easily accessible and highly visible to residents	Y N	
b. Clear, specific	4 3 2 1	
c. Written in age-appropriate language	4 3 2 1	
d. Worded respectfully	4 3 2 1	
e. Expressed in positive terms	4 3 2 1	
4. Staff's verbal communication with children is observed to be:		
a. Clear, specific	4 3 2 1	
b. In age-appropriate language	4 3 2 1	
c. Respectful	4 3 2 1	
d. Expressed in positive terms	4 3 2 1	
e. Delivered in friendly voice tones	4 3 2 1	
5. The arrangement of the units permits a high level of staff/resident interaction, with no unnecessary physical barriers between staff and residents.	4 3 2 1	
6. Random checks of residents' behavior program documentation (point sheets or similar documents) indicate that compliance feedback is being provided in a timely manner.	Y N	
7. Staff/resident ratios on all shifts are adequate to provide for resident and staff safety	Y N	

8. Effective safety precautions are in place for monitoring reactive children.	Y N N/A	
9. Nighttime bed-monitoring procedures are established to insure resident safety and implementation is documented.	Y N	
10. Each unit has identified an appropriate place/procedure for responding to residents' physical/medical complaints.	Y N	
11. Rules and schedules for the use of toilet/bathing facilities provide adequately for the safety of residents.	Y N	
12. Areas set aside for seclusion/restraint are clean, well lighted/ventilated.	Y N N/A	
13. Activity in each seclusion/restraint room can be continuously monitored.	Y N	
14. Equipment for mechanical restraint meets prescribed standards.	Y N	
15. The facility has adequate areas for indoor/outdoor recreation.	4 3 2 1	
16. The facility provides an accredited school for residents.	Y N	
17. There is a designated area for the provision of meals.	Y N	
18. Areas designated for the provision of group therapy are conducive to therapeutic interaction.	4 3 2 1	
19. The area designated for community meetings is conducive to therapeutic interaction.	4 3 2 1	

PRTF COMPLIANCE REVIEW INSTRUMENT (CRI)
Program Section B: Document Review

Reviewer's Name: _____

RATING SCALE: 4 – Exceeds Standards 3 – Meets Standards 2 – Sub-standard 1 – Unacceptable
Y – Yes N – No

Element	Rating	Comments
1. Any behavior program used as a part of treatment is: a. Clear and specific b. Age-appropriate to the targeted group c. Reasonable and workable in the normal course of treatment.	 4 3 2 1 4 3 2 1 4 3 2 1	
2. Adequate staff in-service training is provided, as evidenced by: a. Orientation and supervised on-the-job training is provided to new staff prior to their being assigned independent responsibilities b. A minimum of 20 hours of in-service training (excluding training described in item 3 below) are received by each staff member per year c. Training topics are appropriate to the needs of residential treatment staff d. Trainers are qualified in the area of training they provide.	 Y N Y N Y N Y N	
3. All direct care staff are trained and certified in a professionally recognized method of handling difficult situations, de-escalating problem behaviors, and applying physical restraint when necessary.	Y N	
4. There is documentation that adequate clinical supervision is provided. Therapists, nursing staff and direct care staff receive a minimum of 4 hours of clinical supervision per month, provided through a combination of individual supervision, group supervision and participation in treatment team meetings.	4 3 2 1	
5. All occurrences of seclusion/restraint are documented in a facility-wide log (PRTF only).	Y N N/A	
6. All occurrences of seclusion/restraint are reviewed monthly by an interdisciplinary team.	Y N N/A	
7. Incident reports (accidents, injuries, allegations of staff misconduct) are maintained according to policy. Documentation indicates that incidents have been handled appropriately by the PRTF.	Y N	
8. Child abuse allegations are reported to proper authorities.	Y N N/A	

9. Standards have been developed for evaluating the effectiveness of the facility's program. The evaluation protocol includes, at a minimum:		
a. A comparison of each resident's pre- and post-treatment functional status	Y N	
b. A notation of each resident's discharge disposition	Y N	
c. A comparison of prescribed medications, pre- and post-treatment	Y N	

PRTF Compliance Review Instrument (CRI)
Clinical Services Section A: Resident Record Review

Resident _____ ID# _____ OSCR Case #_____

Age _____ Sex _____ DHS Custody? Yes No Psychiatrist _____ Reviewer_____

Admission date: _____ Discharge target date: _____ Discharge actual date: _____

RATING SCALE : 4 - Exceeds Standards 3 - Meets Standards 2 - Sub-standard 1 - Unacceptable
Y – Yes N – No

Element	Rating	Comments
1. **Resident Record** a. Record is well organized. A key identifies the location of all required documents. b. Copies of documents verifying custody, if other than parents.	Y N Y N N/A	
2. **Admission** a. Resident's FS-IQ is appropriate for the program, documented within the last 12 months. b. Symptom severity warrants residential treatment c. Less restrictive treatment is not appropriate: _____Resident failed to respond to less restrictive treatment _____Adequate treatment options exist in resident's community _____Resident is being stepped-down from acute care d. Parents were informed re: special procedures e. Parents were given information regarding state P&A Agency	Y N Y N Y N Y N N/A Y N	
3. **Assessment** a. Psychiatric evaluation b. Medical history and physical exam c. Psychological evaluation by licensed psychologist within 12 months pre-admission or 14 days post-admission d. Psychosocial assessment 1) Includes developmental profile 2) Includes behavioral assessment 3) Assesses potential family resources e. Educational assessment f. Nursing assessment	Y N Y N Y N Y N 4 3 2 1 4 3 2 1 4 3 2 1 Y N Y N	

OSCR Case #: _____

g. Nutritional assessment, if indicated	Y N N/A	
4. Treatment Planning		
a. Team composition:		
1) Psychiatrist or PMHNP/psychologist & physician	Y N	
2) LCSW **or** RN	Y N	
b. Time lines met:		
1) Initial plan within 72 hours	Y N	
2) Comprehensive plan within 14 days	Y N	
3) Reviews: once at end of first month of stay	Y N N/A	
4) Reviews: once monthly after first month of stay	Y N N/A	
c. Required elements		
1) Multi-axial diagnosis	Y N	
2) Resident's short-/long-term therapeutic needs	Y N	
3) Resident's strengths and liabilities	Y N	
4) Problems to be addressed in treatment	Y N	
5) Goals, measurable objectives, target dates for completion	4 3 2 1	
6) Treatment modalities, clinicians responsible	Y N	
7) Family therapy goals/objectives	Y N	
8) Discharge plan, estimated discharge date	Y N	
d. Reviews:		
1) Note treatment successes, explain failures	4 3 2 1	
2) Identify changes in treatment, if needed	Y N N/A	
3) Re-assess need for residential vs. less-restrictive treatment	Y N	
4) Assess progress in relation to projected discharge date	Y N	
e. Evidence that resident and parent/guardian actively participate	Y N	
f. Evidence that physician directs treatment	Y N	
g. Evidence of interdisciplinary collaboration in planning	Y N	
5. Treatment Documentation		
a. All modalities:		
1) Date/length of session	Y N	
2) Summary of content/process	4 3 2 1	
3) Sessions clearly have therapeutic focus	4 3 2 1	
4) Outcome of session	4 3 2 1	
5) Therapist's signature	Y N	
b. Individual therapy:		
1) Provided minimum 1 hr/week	Y N	
2) Resident's mental status	Y N	
3) Progress towards treatment goals	4 3 2 1	
4) Progress in relation to discharge date addressed at least monthly	4 3 2 1	
c. Family therapy:		
1) provided 2 x month (2+ hrs from PRTF, 1 in-person + 1 phone session)	Y N	
2) Resident's response to family members	4 3 2 1	
d. Group therapy:		

1) Provided 3 hrs in minimum 3 sessions/week	Y N	
e. Milieu therapy:		
1) Community meetings held daily	Y N	
2) Therapeutic milieu provided 24 hours/day, 7 days/week	4 3 2 1	
3) Resident's participation in community meetings	4 3 2 1	
4) Milieu notes behaviorally-focused	4 3 2 1	
f. Medication:		
1) All orders in chart	Y N N/A	
2) Administration timely and accurate (MAR)	Y N N/A	
3) Reasons given for PRN meds	Y N N/A	
4) There were no orders for PRN pharmacological restraint	Y N	
5) Informed consent for meds properly executed	Y N N/A	
6) Resident assessed for side effects on admission, every 60 days, and at discharge	Y N N/A	
g. Therapeutic Pass:		
1) Goals were identified	Y N N/A	
2) Outcome of goals was documented	Y N N/A	
h. Therapeutic Leave:		
1) Authorized by physician's or PMHNP's order	Y N	
2) Not taken during 14-day assessment period	Y N	
3) Date/time patient checked out/in	Y N	
4) Required time of return	Y N	
5) Name of person with whom leave will be spent	Y N	
6) Resident's condition at check-out/in, vital signs, mental status	Y N	
7) Name/signature of person with whom child is leaving/returning	Y N	
8) Name/signature of staff checking child out/in	Y N	
9) Medications provided/returned noted, include number of doses	Y N N/A	
10) Medication instructions given, in lay terms	4 3 2 1	
11) Therapeutic goals for leave	4 3 2 1	
12) Outcome of leave assessed by therapist within 72 hours of return	Y N N/A	
6. Special Procedures		
a. Least restrictive effective intervention was used	4 3 2 1	
b. Seclusion/restraint initiated only by physician, PMHNP or RN	Y N N/A	
c. Personal restraint administered by trained personnel	Y N N/A	
d. Physician or PMHNP identified end times for pharmacological restraint	Y N N/A	
e. Documentation includes:		
1) Date/time procedure started/ended	Y N	
2) Names of staff involved in applying or monitoring	Y N	
3) Whether or not therapeutic leave ended w/in last 12 hours	Y N	
4) Reason procedure was used	4 3 2 1	
5) Which less restrictive measures were used, how they failed	4 3 2 1	

6) Order obtained from MD or PMHNP within 1 hour	Y N	
7) Orders for up to 9 year old children are 1 hour; 9-21 years old are 2 hours	Y N	
8) Order renewed when original order expires	Y N	
9) Clear criteria for ending procedure	Y N N/A	
10) Resident's health/comfort assessed every 15 minutes	Y N N/A	
11) Vital signs taken every hour	Y N	
12) In-person assessment conducted by physician, PMHNP, or RN within 1 hour, regardless of length of procedure	Y N	
13) Assessment includes		
a) Resident/s physical/psychological status	Y N	
b) Resident's behavior	Y N	
c) Appropriateness of Intervention	Y N	
d) Resulting complications	Y N	
14) Procedure ended at the earliest possible time	Y N N/A	
15) Resident's response to procedure	4 3 2 1	
f. Treatment plan modified within 1 working day of incident	Y N	
g. Parents notified within 24 hours (or had waived right in writing)	Y N	
h. Incident processed with resident by staff within 24 hours	Y N	
i. Staff debriefing conducted within 24 hours	Y N N/A	
7. Discharge/Aftercare		
a. Provisional plan developed 1 week prior to discharge	Y N	
b. Provisional plan includes:		
1) Anticipated date of discharge	Y N	
2) Recommendations for parents/caregivers	Y N	
3) Educational summary and recommendations	Y N	
4) Recommendations for mental health care providers	Y N	
c. Final aftercare plan includes:		
1) Dates of admission and discharge	Y N	
2) Person/agency to whom resident will be released	Y N	
3) Address where resident will reside	Y N	
4) Multi-axial diagnosis	Y N	
5) Medication information, in lay terms	Y N N/A	
6) Recommendations for parents/caregivers	4 3 2 1	
7) Educational summary and recommendations for teachers	4 3 2 1	
8) Recommendations for providers of follow-up mental health care	4 3 2 1	
9) Names, addresses, phone numbers of follow-up mental health care providers	Y N	
10) Date/times of initial aftercare appointments	Y N	
d. Parent received:		
1) Minimum of one week's supply of medications	Y N N/A	
2) Prescriptions for 30-day supply of meds	Y N N/A	
3) Copy of aftercare plan	Y N N/A	
e. Documentation that educational summary and	Y N	

	recommendations were mailed to the resident's school within 24 hours post-discharge.		
f.	Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care providers within 2 weeks post-discharge.	Y N	

General Comments: